RIW
Rehabilitation Institute of Washington PLLC

# REFERRAL FORM

**Please Fax to (206) 859-5031. Please attach any supporting documents or records.**

## PATIENT INFORMATION

Patient Name _____ Date of Birth _____
Address _____ Home Phone _____
City _____ State _____ Zip _____ Cell Phone _____

Primary Insurance _____ Policy/Claim Number _____
Contact Name _____ Phone Number _____
Secondary Insurance _____ Policy/Claim Number _____
Contact Name _____ Phone Number _____

*Diagnosis\Reason for Referral:* _____

**Multidisciplinary Program Evaluation:**

☐ Brain Injury Rehabilitation Program
☐ Concussion Clinic
☐ Pain Management Program
☐ Work Rehabilitation Program

**Individual Evaluations and Therapy Services (check all that apply):**

☐ Rehabilitation Medicine Evaluation/Treatment
☐ Occupational Medicine Evaluation/Treatment
☐ Neuropsychological Evaluation
☐ Psychological Evaluation/Treatment
☐ Behavioral health assessment/intervention (BHI)
☐ Speech Therapy
☐ Physical Therapy
☐ Occupational Therapy
☐ Other: _____

Comments:

_____

## REFERRAL SOURCE INFORMATION

Provider's Name/Specialty: _____ Office Phone: _____
Clinic name and Address: _____ Office Fax: _____
Provider Signature: _____

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**Seattle, WA 98109**
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***Restoring quality and function to people's lives.***